

REVIEW OF MEDICARE REQUESTS FOR EXPEDITED APPEAL CASES**WS-AP2**

Name/HI Number	Organ. Determ. Date	Request Rec'd. Date (Exped. Appeal)	Expedited decision in 72 hrs?* 1) decision to expedite correct? 2) Notification to Enrollee sent?	<u>Favorable:</u> Oral notice in 72 hrs?*F/U in writing 2 working days? Date service effectuated?	<u>Unfav.</u> Notice to Enrollee date?	<u>Unfav. decision</u> To HCFA contractor date -in 24 hours? (Exped. Appeal)	Transfer to Standard process justified? Notice to enrollee date ?	Comments Overturned Decision effectuated date? (In 30 days?) POS?

Standard: 95 percent correct.

Determination: Transfer results of this sample to the appropriate requirements at AP01 - AP12 of the *Review Guide*. See Column Explanations for coded requirements related to specific

REVIEW OF MEDICARE REQUESTS FOR EXPEDITED APPEAL CASES

WS-AP2

Requirement:

***ALL SERVICE RELATED DECISIONS MUST BE MADE AS EXPEDITIOUSLY AS THE ENROLLEE'S HEALTH CONDITION REQUIRES.**

! The M+CO must make the reconsideration decision within 72 hours of receipt of the reconsideration request. If the M+CO cannot issue a fully favorable reconsideration, it must forward the case to HCFA's contractor within 24 hours of expiration of 72 hours, or expiration of the extension. The M+CO is not allowed to issue an unfavorable decision to an enrollee, but is required to notify enrollee that case is forwarded to HCFA's contractor. If the HCFA contractor's reconsidered determination is to hold the M+CO liable, the M+CO must provide, authorize or make payment for the service within 60-calendar days from the date of HCFA's determination.

! The M+CO must expedite: 1) physician requests for expedited appeal (where the physician is an authorized representative), 2) enrollee with physician support statements (oral or in writing), 3) all other cases where the enrollee's life, health or the enrollee's ability to regain maximum function would be jeopardized by use of the standard appeal time frames. All of above, M+CO expedited appeals and decisions not to expedite, must be processed as standard appeals and the enrollee or representative must be notified promptly (orally) with a follow-up in writing within two work-days.

! The M+CO must forward an expedited appeal to HCFA's contractor within 24 hours of affirmation of the original adverse organization determination in whole or in part.

Purpose: To determine whether the M+CO complies with regulatory requirements of identifying organization determinations, and processing requests for expedited organization determinations and expedited Medicare appeal cases in a timely manner.

Sample: Universe includes: any expedited appeal. In the notification of a site visit letter, reviewer will request the M+CO to: 1) provide a list of all expedited reconsideration cases referred to HCFA's contractor by the M+CO during the 6-month period ending with the month prior to the scheduled visit (the specific months should be specified in the letter); and 2) provide a list of & have available onsite (e.g., 15, 30, all, a specific number, or specified cases) favorable reconsideration decisions. Upon receipt of the lists, approximately 2 weeks prior to the site visit, the reviewer will select 30 cases in accordance with the random selection methods discussed in the *Review Guide* Instructions, under Sampling Methodology. (*Note: During focused reviews, HCFA staff may elect to increase sample sizes to 100 cases or more, as deemed appropriate by the Agency.*) Five (5) to seven (7) days before the site visit, reviewer will notify the M+CO of the specific units of analysis. The M+CO will have all necessary documentation for the units of analysis available upon the reviewer's arrival onsite.

Column Explanations:

' **Name/HI Number:** Self-explanatory. Number optional.

' **Organization Determ Date:** The date of the organization determination starts the 60-calendar days during which time the beneficiary may appeal.

' **Request Rec'd Date:** Regulations specify the time frames for requesting reconsideration; otherwise, the organization determination is final and binding.

' **Expedited Decision in 72 hours? 1) Decision to expedite correct? 2) Notification sent?** Did the M+CO make the correct decision about whether or not to expedite the request and notify the enrollee within 72 hours of the request? [If the M+CO granted itself up to a 14-day extension, is the extension appropriate? Was justification (the reason and the extension needed) for additional time documented (or did the enrollee request it?)] Was this decision correct? Cases that must be expedited: 1) physician requested (any physician - affiliated and unaffiliated), and 2) physician support for enrollee's request. Was notification sent to the enrollee within

required time frames? Transfer results to AP01 & AP12

‘ **If original decision notification not in writing, written notice sent in 2 working days?** If favorable, was oral notice given to enrollee with 72 hours with follow-up in writing within 2 working days. If favorable, indicate the date the service effectuated.

‘ **Unfavorable Notice to the Enrollee Date,** Use this column to show what date the unfavorable notice was sent.

‘ **To HCFA contractor Date?** If for standard appeal cases, the M+CO's reconsideration recommendation is unfavorable or partially favorable, it must send the case to HCFA's contractor within 30-calendar days from the date of the request. The M+CO may not exceed this time limit, even for medical records. Was the case appropriately developed and prepared for HCFA? **Transfer results to AP10.** For expedited organization determination and expedited appeals, the M+CO must send the case to HCFA contractor within 24 hours of the denial decision. (Not applicable for standard organization determinations) If favorable, indicate date review was effectuated.

Transferred From Std. Process Justified? Indicate the date the notice was sent to the enrollee, which explains the transfer of the request to the standard appeal process.

Comments: Self-explanatory. You may want to include comments here (e.g., reason for denial, emergency/urgently needed care) that would help you focus on trends.

The reviewer could also include: notice reasons, was an extension granted? Was it justified? Explain if decision was within 72 hours. Note if notice correct, e.g., were grievance rights given? Was decision to transfer between the standard process and the expedited process made correctly? Was a reversal of a decision effectuated as expeditiously as enrollees condition requires, but no later than the correct number of days for the situation?